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H.L.C.	
Amendment no.:	<u>1c</u>
Date offered:	<u>10/27/05</u>
Disposition:	<u>Not Agreed to by</u> <u>21 yeas and 27 nays</u>

AMENDMENT TO MR. BARTON'S AMENDMENT TO
SUBTITLE A

OFFERED BY MR. BROWN OF OHIO

(Amendment to Medicaid Reconciliation Provisions)

**(Page & line nos. refer to Amendment of October 26, 2005
12:12 PM)**

In the proposed subtitle A, amend section 3131 to
read as follows:

1 **SEC. 3131. MEDICAID HOME AND COMMUNITY-BASED SERV-**
2 **ICES OPTIONAL BENEFIT.**

3 (a) HOME AND COMMUNITY-BASED SERVICES AS AN
4 OPTIONAL BENEFIT FOR INDIVIDUALS ELIGIBLE FOR
5 MEDICAL ASSISTANCE.—Title XIX of the Social Security
6 Act (42 U.S.C. 1396 et seq.) is amended—

7 (1) in section 1905(a)—

8 (A) in paragraph (27), by striking “and”
9 at the end;

10 (B) by redesignating paragraph (28) as
11 paragraph (29); and

12 (C) by inserting after paragraph (27), the
13 following:

14 “(28) subject to section 1930A, such home and
15 community-based services (as defined in subsections
16 (c)(4)(B) and (d)(5)(C)(i) of section 1915 (not in-
17 cluding payment for room and board but including,

1 in the case of services described in section
2 1915(c)(4)(B), any other services requested by a
3 State and approved by the Secretary under such sec-
4 tion)) as the State shall specify in a State plan
5 amendment; and”;

6 (2) by inserting after section 1930, the fol-
7 lowing:

8 “HOME AND COMMUNITY-BASED SERVICES

9 “SEC. 1930A. (a) IN GENERAL.—A State may pro-
10 vide through a State plan amendment for the provision
11 of such home and community-based services under section
12 1905(a)(28) as the State shall specify for individuals eligi-
13 ble for medical assistance under the State plan (without
14 determining that but for the provision of such services the
15 individuals would require the level of care provided in a
16 hospital or a nursing facility or intermediate care facility
17 for the mentally retarded), but only if the State meets the
18 following requirements:

19 “(1) NEEDS-BASED CRITERIA FOR ELIGIBILITY
20 FOR, AND RECEIPT OF, HOME AND COMMUNITY-
21 BASED SERVICES.—The State establishes needs-
22 based criteria for determining an individual’s eligi-
23 bility under the State plan for medical assistance for
24 such home and community-based services, and if the
25 individual is eligible for such services, the specific

1 home and community-based services that the indi-
2 vidual will receive.

3 “(2) ESTABLISHMENT OF MORE STRINGENT
4 NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITU-
5 TIONALIZED CARE.—The State establishes needs-
6 based criteria for determining whether an individual
7 requires the level of care provided in a hospital, a
8 nursing facility, or an intermediate care facility for
9 the mentally retarded under the State plan or under
10 any waiver of such plan that are more stringent
11 than the needs-based criteria established under para-
12 graph (1) for determining eligibility for home and
13 community-based services.

14 “(3) PROJECTION OF NUMBER OF INDIVIDUALS
15 TO BE PROVIDED HOME AND COMMUNITY-BASED
16 SERVICES.—The State submits to the Secretary, in
17 such form and manner, and upon such frequency as
18 the Secretary shall specify, the projected number of
19 individuals to be provided home and community-
20 based services.

21 “(4) CRITERIA BASED ON INDIVIDUAL ASSESS-
22 MENT.—

23 “(A) IN GENERAL.—The criteria estab-
24 lished by the State for purposes of paragraphs
25 (1) and (2) requires an assessment of an indi-

vidual's support needs and capabilities, and
may take into account the inability of the indi-
vidual to perform 1 or more activities of daily
living (as defined in section 7702B(c)(2)(B) of
the Internal Revenue Code of 1986) or the need
for significant assistance to perform such activi-
ties, and such other risk factors as the State
determines to be appropriate.

“(B) ADJUSTMENT AUTHORITY.—The
State plan amendment provides for modification
of the criteria established under paragraph (1)
(without having to obtain prior approval from
the Secretary) in the event that the enrollment
of individuals eligible for home and community-
based services exceeds the projected enrollment
submitted for purposes of paragraph (3), but
only if—

“(i) the State provides at least 60
days notice to the Secretary and the public
of the proposed modification;

“(ii) the State deems an individual re-
ceiving home and community-based serv-
ices on the basis of the most recent version
of the criteria in effect prior to the effec-
tive date of the modification to continue to

1 be eligible for such services after the effec-
2 tive date of the modification and until such
3 time as the individual no longer meets the
4 standard for receipt of such services under
5 such pre-modified criteria; and

6 “(iii) after the effective date of such
7 modification, the State applies the criteria
8 for determining whether an individual re-
9 quires the level of care provided in a hos-
10 pital, a nursing facility, or an intermediate
11 care facility for the mentally retarded
12 under the State plan or under any waiver
13 of such plan which applied prior to the ap-
14 plication of the more stringent criteria de-
15 veloped under paragraph (2).

16 “(5) INDEPENDENT EVALUATION AND ASSESS-
17 MENT.—

18 “(A) ELIGIBILITY DETERMINATION.—The
19 State uses an independent evaluation for mak-
20 ing the determinations described in paragraphs
21 (1) and (2).

22 “(B) ASSESSMENT.—In the case of an in-
23 dividual who is determined to be eligible for
24 home and community-based services, the State

1 uses an independent assessment, based on the
2 needs of the individual to—

3 “(i) determine a necessary level of
4 services and supports to be provided, con-
5 sistent with an individual’s physical and
6 mental capacity,

7 “(ii) prevent the provision of unneces-
8 sary or inappropriate care; and

9 “(iii) establish an individualized care
10 plan for the individual in accordance with
11 paragraph (7).

12 “(6) ASSESSMENT.—The independent assess-
13 ment required under paragraph (5)(B) shall include
14 the following:

15 “(A) An objective evaluation of an individ-
16 ual’s inability of the individual to perform 1 or
17 more activities of daily living (as defined in sec-
18 tion 7702B(c)(2)(B) of the Internal Revenue
19 Code of 1986) or the need for significant assist-
20 ance to perform such activities, and of the indi-
21 vidual’s ability to engage in major life activities
22 such as walking, seeing, hearing, breathing,
23 speaking, working, performing manual tasks,
24 learning, thinking, concentrating, interacting

1 with others, sleeping, and any other appropriate
2 activities.

3 “(B) A face-to-face evaluation of the indi-
4 vidual by an individual trained in the assess-
5 ment and evaluation of individuals whose phys-
6 ical or mental conditions trigger a potential
7 need for home and community-based services.

8 “(C) Where appropriate, consultation with
9 the individual’s family, spouse, guardian, or
10 other responsible individual.

11 “(D) Consultation with appropriate treat-
12 ing and consulting health and support profes-
13 sionals caring for the individual.

14 “(E) An examination of the individual’s
15 relevant history, medical records, and care and
16 support needs, guided by best practices and re-
17 search on effective strategies that result in im-
18 proved health and quality of life outcomes.

19 “(F) If the State offers individuals the op-
20 tion to self-direct the purchase of, or control the
21 receipt of, home and community-based service,
22 an evaluation of the ability of the individual or
23 the individual’s representative to self-direct the
24 purchase of, or control the receipt of, such serv-
25 ices if the individual so elects.

1 “(7) INDIVIDUALIZED CARE PLAN.—

2 “(A) IN GENERAL.—In the case of an indi-
3 vidual who is determined to be eligible for home
4 and community-based services, the State uses
5 the independent assessment required under
6 paragraph (5)(B) to establish a written individ-
7 ualized care plan for the individual.

8 “(B) PLAN REQUIREMENTS.—The State
9 ensures that the individualized care plan for an
10 individual—

11 “(i) is developed—

12 “(I) in consultation with the indi-
13 vidual, the individual’s treating physi-
14 cian, health care or support profes-
15 sional, or other appropriate individ-
16 uals, as defined by the State, and,
17 where appropriate the individual’s
18 family, caregiver, or representative;
19 and

20 “(II) taking into account the ex-
21 tent of, and need for, any family or
22 other supports for the individual;

23 “(ii) identifies the necessary home and
24 community-based services to be furnished
25 to the individual (or, if the individual elects

1 to self-direct the purchase of, or control
2 the receipt of, such services, funded for the
3 individual); and

4 “(iii) is reviewed at least annually and
5 as needed when there is a significant
6 change in the individual’s circumstances.

7 “(C) STATE OPTION TO OFFER ELECTION
8 FOR SELF-DIRECTED SERVICES.—

9 “(i) INDIVIDUAL CHOICE.—At the op-
10 tion of the State, the State may allow an
11 individual or the individual’s representative
12 to elect to receive self-directed home and
13 community-based services in a manner
14 which gives them the most control over
15 such services consistent with the individ-
16 ual’s abilities and the requirements of
17 clause (ii).

18 “(ii) SELF-DIRECTED SERVICES.—The
19 term ‘self-directed’ means, with respect to
20 the home and community-based services of-
21 fered under the State plan amendment,
22 such services for the individual which are
23 planned and purchased under the direction
24 and control of such individual or the indi-
25 vidual’s authorized representative, includ-

1 ing the amount, duration, scope, provider,
2 and location of such services, under the
3 State plan consistent with the following re-
4 quirements:

5 “(I) ASSESSMENT.—There is an
6 assessment of the needs, capabilities,
7 and preferences of the individual with
8 respect to such services.

9 “(II) SERVICE PLAN.—Based on
10 such assessment, there is developed
11 jointly with such individual or the in-
12 dividual’s authorized representative a
13 plan for such services for such indi-
14 vidual that is approved by the State
15 and that—

16 “(aa) specifies those services
17 which the individual or the indi-
18 vidual’s authorized representative
19 would be responsible for direct-
20 ing;

21 “(bb) identifies the methods
22 by which the individual or the in-
23 dividual’s authorized representa-
24 tive will select, manage, and dis-
25 miss providers of such services;

1 “(cc) specifies the role of
2 family members and others whose
3 participation is sought by the in-
4 dividual or the individual’s au-
5 thorized representative with re-
6 spect to such services;

7 “(dd) is developed through a
8 person-centered process that is
9 directed by the individual or the
10 individual’s authorized represent-
11 ative, builds upon the individual’s
12 capacity to engage in activities
13 that promote community life and
14 that respects the individual’s
15 preferences, choices, and abilities,
16 and involves families, friends,
17 and professionals as desired or
18 required by the individual or the
19 individual’s authorized represent-
20 ative;

21 “(ee) includes appropriate
22 risk management techniques that
23 recognize the roles and sharing of
24 responsibilities in obtaining serv-
25 ices in a self-directed manner and

1 assure the appropriateness of
2 such plan based upon the re-
3 sources and capabilities of the in-
4 dividual or the individual's au-
5 thorized representative; and

6 “(ff) may include an individ-
7 ualized budget which identifies
8 the dollar value of the services
9 and supports under the control
10 and direction of the individual or
11 the individual's authorized rep-
12 resentative.

13 “(III) BUDGET PROCESS.—With
14 respect to individualized budgets de-
15 scribed in subclause (II)(ff), the State
16 plan amendment—

17 “(aa) describes the method
18 for calculating the dollar values
19 in such budgets based on reliable
20 costs and service utilization;

21 “(bb) defines a process for
22 making adjustments in such dol-
23 lar values to reflect changes in
24 individual assessments and serv-
25 ice plans; and

1 “(cc) provides a procedure
2 to evaluate expenditures under
3 such budgets.

4 “(8) QUALITY ASSURANCE; CONFLICT OF IN-
5 TEREST STANDARDS.—

6 “(A) QUALITY ASSURANCE.—The State en-
7 sures that the provision of home and commu-
8 nity-based services meets Federal and State
9 guidelines for quality assurance.

10 “(B) CONFLICT OF INTEREST STAND-
11 ARDS.—The State establishes standards for the
12 conduct of the independent evaluation and the
13 independent assessment to safeguard against
14 conflicts of interest.

15 “(9) REDETERMINATIONS AND APPEALS.—The
16 State allows for at least annual redeterminations of
17 eligibility, and appeals in accordance with the fre-
18 quency of, and manner in which, redeterminations
19 and appeals of eligibility are made under the State
20 plan.

21 “(10) PRESUMPTIVE ELIGIBILITY FOR ASSESS-
22 MENT.—

23 “(A) IN GENERAL.—The State, at its op-
24 tion, elects to provide for a period of presump-
25 tive eligibility for an individual that is limited

1 to medical assistance for carrying out the inde-
2 pendent evaluation and assessment under para-
3 graph (5) to determine an individual's eligibility
4 for home and community-based services, and if
5 the individual is eligible for such services, the
6 specific home and community-based services
7 that the individual will receive.

8 “(B) APPLICATION OF EXISTING RULES.—

9 In the case of a State that makes such an elec-
10 tion, the State provides for a period of pre-
11 sumptive eligibility in the same manner as the
12 State may provide for such a period under sec-
13 tion 1920B (except that subsection (d)(2) of
14 that section is applied by substituting ‘section
15 1903’ for ‘clause (4) of the first sentence of
16 section 1905(b)’).

17 “(b) DEFINITION OF INDIVIDUAL’S REPRESENTA-
18 TIVE.—In this section, the term ‘individual’s representa-
19 tive’ means, with respect to an individual, a parent, a fam-
20 ily member, or a guardian of the individual, an advocate
21 for the individual, or any other individual who is author-
22 ized to represent the individual.

23 “(c) NO EFFECT ON 1915 OR 1115 WAIVERS.—

24 Nothing in this section shall be construed as effecting the
25 option of a State to offer home and community-based serv-

1 ices under a waiver under subsections (c) or (d) of section
2 1915 or under section 1115.”.

3 (2) CONFORMING AMENDMENT.—Section
4 1902(a)(10)(C)(iv) of such Act (42 U.S.C.
5 1396a(a)(10)(C)(iv)) is amended by inserting “or
6 (28)” after “(24)”.

7 (b) STATE OPTION TO EXPAND HOME AND COMMU-
8 NITY-BASED SERVICES TO ADDITIONAL AT-RISK INDIVID-
9 UALS.—

10 (1) IN GENERAL.—Section 1930A of the Social
11 Security Act (42 U.S.C. 1396d(y)) (as added by
12 subsection (a)) is amended—

13 (A) by redesignating subsection (b) as sub-
14 section (c); and

15 (B) by inserting after subsection (a) the
16 following:

17 “(b) HOME AND COMMUNITY-BASED SERVICES FOR
18 AT-RISK INDIVIDUALS.—

19 “(1) IN GENERAL.—If a State elects to offer
20 under the State plan medical assistance for home
21 and community-based services in accordance with
22 section 1905(a)(28) and subsection (a), the State
23 may elect, subject to paragraph (3), to offer such
24 services to an individual described in paragraph (2)
25 who is determined on the basis of an independent

1 evaluation to meet the criteria established under
2 subsection (a)(1) for eligibility for, and receipt of,
3 such services.

4 “(2) INDIVIDUAL DESCRIBED.—For purposes of
5 paragraph (1), an individual described in this para-
6 graph is an individual whose income (as determined
7 under section 1612, but without regard to subsection
8 (b) thereof) does not exceed such percent of the sup-
9 plemental security income benefit rate established by
10 section 1611(b)(1) as the State may establish (but
11 not to exceed 300 percent).

12 “(3) APPLICATION OF RULES FOR OFFERING
13 HOME AND COMMUNITY-BASED SERVICES AS AN OP-
14 TIONAL BENEFIT.—The requirements of subsection
15 (a) shall apply to the provision of home and commu-
16 nity-based services to eligible individuals under this
17 subsection.”.

18 (2) CONFORMING AMENDMENT.—Section
19 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is
20 amended in the matter preceding subparagraph (A),
21 by inserting “1930A(b)” after “1905(p)(1)”.

22 (c) QUALITY OF CARE MEASURES.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services (in this subsection referred to as
25 the “Secretary”), acting through the Director of the

1 Agency for Healthcare Research and Quality, shall
2 consult with consumers, health and social service
3 providers and other professionals knowledgeable
4 about long-term care services and supports to de-
5 velop program performance indicators, client func-
6 tion indicators, and measures of client satisfaction
7 with respect to home and community-based services
8 offered under State medicaid programs (under a
9 waiver approved under section 1115 or 1915 of the
10 Social Security Act or under section 1930A of such
11 Act (as added by subsections (a) and (b))).

12 (2) BEST PRACTICES.—The Secretary shall—

13 (A) use the indicators and measures devel-
14 oped under paragraph (1) to assess such home
15 and community-based services, the outcomes as-
16 sociated with the receipt of such services (par-
17 ticularly with respect to the health and welfare
18 of the recipient of the services), and the overall
19 system for providing home and community-
20 based services under the medicaid program
21 under title XIX of the Social Security Act; and

22 (B) make publicly available the best prac-
23 tices identified through such assessment and a
24 comparative analyses of the system features of
25 each State.

At the end of the proposed subtitle, add the following new chapter:

1 **Chapter 6—Additional Miscellaneous**
2 **Provisions**

3 **SEC. 3151. PAYMENT UNDER MEDICARE ADVANTAGE PRO-**
4 **GRAM FOR PART A AND PART B SERVICES**
5 **BASED ONLY ON LOCAL FEE-FOR-SERVICE**
6 **COSTS (AAPCC).**

7 Section 1853(a)(1) of the Social Security Act (42
8 U.S.C. 1395w-23(a)(1)) is amended—

9 (1) in subparagraph (A)—

10 (A) in clause (ii), by striking “BEGINNING
11 WITH 2006” and “beginning with 2006” and in-
12 serting “FOR 2006” and “for 2006”, respec-
13 tively; and

14 (B) by adding at the end the following new
15 clause:

16 “(iii) PAYMENT BASED ON LOCAL
17 FEE-FOR-SERVICE PAYMENTS BEGINNING
18 WITH 2007.—For years beginning with
19 2007, the payment amount shall be equal
20 to $\frac{1}{12}$ of the adjusted average per capita
21 cost calculated under subsection (c)(1)(D)
22 with respect to that individual for that
23 area, adjusted under subparagraph (C)

1 and reduced by the amount of any reduc-
2 tion elected under section 1854(f)(1)(E).”;
3 and

4 (2) in subparagraph (B), by striking “BEGIN-
5 NING WITH 2006” and inserting “FOR 2006”.

6 **SEC. 3152. ELIMINATION OF MEDICARE ADVANTAGE RE-**
7 **GIONAL PLAN STABILIZATION FUND.**

8 (a) IN GENERAL.—Subsection (e) of section 1858 of
9 the Social Security Act (42 U.S.C. 1395w–27a) is re-
10 pealed.

11 (b) CONFORMING AMENDMENT.—Section 1858(f)(1)
12 of the Social Security Act (42 U.S.C. 1395w–27a(f)(1))
13 is amended by striking “subject to subsection (e),”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect as if included in the enact-
16 ment of section 221(c) of the Medicare Prescription Drug,
17 Improvement, and Modernization Act of 2003 (Public Law
18 108–173; 117 Stat. 2181).

19 **SEC. 3153. PHASE-OUT OF RISK ADJUSTMENT BUDGET NEU-**
20 **TRALITY IN DETERMINING THE AMOUNT OF**
21 **PAYMENTS TO MEDICARE ADVANTAGE ORGA-**
22 **NIZATIONS.**

23 (a) IN GENERAL.—Section 1853 of the Social Secu-
24 rity Act (42 U.S.C. 1395w–23) is amended—

25 (1) in subsection (j)(1)—

1 (A) in subparagraph (A)—

2 (i) by inserting “(or, beginning with
3 2007, $\frac{1}{12}$ of the applicable amount deter-
4 mined under subsection (k)(1))” after
5 “1853(c)(1)”; and

6 (ii) by inserting “(for years before
7 2007)” after “adjusted as appropriate”;

8 (B) in subparagraph (B), by inserting
9 “(for years before 2007)” after “adjusted as
10 appropriate”; and

11 (2) by adding at the end the following new sub-
12 section:

13 “(k) DETERMINATION OF APPLICABLE AMOUNT FOR
14 PURPOSES OF CALCULATING THE BENCHMARK
15 AMOUNTS.—

16 “(1) APPLICABLE AMOUNT DEFINED.—For
17 purposes of subsection (j), subject to paragraph (2),
18 the term ‘applicable amount’ means for an area—

19 “(A) for 2007—

20 “(i) if such year is not specified under
21 subsection (c)(1)(D)(ii), an amount equal
22 to the amount specified in subsection
23 (c)(1)(C) for the area for 2006—

24 “(I) first adjusted by the re-
25 scaling factor for 2006 for the area

1 (as made available by the Secretary in
2 the announcement of the rates on
3 April 4, 2005, under subsection
4 (b)(1), but excluding any national ad-
5 justment factors for coding intensity
6 and risk adjustment budget neutrality
7 that were included in such factor);
8 and
9 “(II) then increased by the na-
10 tional per capita MA growth percent-
11 age, described in subsection (c)(6) for
12 that succeeding year, but not taking
13 into account any adjustment under
14 subparagraph (C) of such subsection
15 for a year before 2004;
16 “(ii) if such year is specified under
17 subsection (c)(1)(D)(ii), an amount equal
18 to the greater of—
19 “(I) the amount determined
20 under clause (i) for the area for the
21 year; or
22 “(II) the amount specified in
23 subsection (c)(1)(D) for the area for
24 the year; and
25 “(B) for a subsequent year—

1 “(i) if such year is not specified under
2 subsection (c)(1)(D)(ii), an amount equal
3 to the amount determined under this para-
4 graph for the area for the previous year,
5 increased by the national per capita MA
6 growth percentage, described in subsection
7 (c)(6) for that succeeding year, but not
8 taking into account any adjustment under
9 subparagraph (C) of such subsection for a
10 year before 2004; and

11 “(ii) if such year is specified under
12 subsection (c)(1)(D)(ii), an amount equal
13 to the greater of—

14 “(I) the amount determined
15 under clause (i) for the area for the
16 year; or

17 “(II) the amount specified in
18 subsection (c)(1)(D) for the area for
19 the year.

20 “(2) ADJUSTMENT.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (D), in the case of 2007 through
23 2010, the applicable amount determined under
24 paragraph (1) shall be increased by a factor
25 equal to 1 plus the product of—

1 “(i) the percent determined under
2 subparagraph (B) for the year; and

3 “(ii) the applicable percent for the
4 year under subparagraph (C).

5 “(B) PERCENT DETERMINED.—

6 “(i) IN GENERAL.—For purposes of
7 subparagraph (A)(i), subject to clause (ii),
8 the percent determined under this subpara-
9 graph for a year is a percent equal to a
10 fraction—

11 “(I) the numerator of which is an
12 amount equal to—

13 “(aa) the Secretary’s esti-
14 mate of the total payments that
15 would have been made under this
16 part in the year if all the month-
17 ly payment amounts for all MA
18 plans were equal to $\frac{1}{12}$ of the
19 annual MA capitation rate under
20 subsection (c)(1) for the area and
21 year; minus

22 “(bb) the Secretary’s esti-
23 mate of the total payments that
24 would have been made under this
25 part in the year if all the month-

1 ly payment amounts for all MA
2 plans were equal to $\frac{1}{12}$ of the
3 MA area-specific non-drug
4 monthly benchmark amount
5 under subsection (j) for the area
6 and year; and

7 “(II) the denominator of which is
8 equal to the total amount estimated
9 for the year under subclause (I)(bb).

10 “(ii) REQUIREMENTS.—In estimating
11 the amounts under clause (i), the
12 Secretary—

13 “(I) shall—

14 “(aa) use a complete set of
15 the most recent and representa-
16 tive Medicare Advantage risk
17 scores under subsection (a)(3)
18 that are available from the risk
19 adjustment model announced for
20 the year;

21 “(bb) adjust the risk scores
22 to reflect changes in treatment
23 and coding practices in the fee-
24 for-service sector;

1 “(cc) adjust the risk scores
2 for differences in coding patterns
3 between Medicare Advantage
4 plans and providers under part A
5 and B to the extent that the Sec-
6 retary has identified such dif-
7 ferences;

8 “(dd) as necessary, adjust
9 the risk scores for late data sub-
10 mitted by Medicare Advantage
11 organizations;

12 “(ee) as necessary, adjust
13 the risk scores for lagged cohorts;
14 and

15 “(ff) as necessary, adjust
16 the risk scores for changes in en-
17 rollment in Medicare Advantage
18 plans during the year; and

19 “(II) may take into account the
20 estimated health risk of enrollees in
21 preferred provider organization plans
22 (including MA regional plans) for the
23 year.

24 In order to make the adjustment required
25 under item (cc) and to ensure payment ac-

1 curacy, the Secretary shall conduct an
2 analysis of the differences described in
3 such item. The Secretary shall complete
4 such analysis by a date necessary to ensure
5 that the results of such analysis are incor-
6 porated into the payment rates for a year
7 not later than 2008. In conducting such
8 analysis, the Secretary shall use data sub-
9 mitted with respect to 2004 and subse-
10 quent years, as available.

11 “(C) APPLICABLE PERCENT.—For pur-
12 poses of subparagraph (A)(ii), the term ‘appli-
13 cable percent’ means—

14 “(i) for 2007, 55 percent;

15 “(ii) for 2008, 40 percent;

16 “(iii) for 2009, 25 percent; and

17 “(iv) for 2010, 5 percent.

18 “(D) TERMINATION OF ADJUSTMENT.—

19 The Secretary shall not make any adjustment
20 under subparagraph (A) in a year if the
21 amount estimated under subparagraph
22 (B)(i)(I)(bb) for the year is equal to or greater
23 than the amount estimated under subparagraph
24 (B)(i)(I)(aa) for the year.

25 “(3) NO ADDITIONAL ADJUSTMENTS.—

1 “(A) IN GENERAL.—Except for the adjust-
2 ment provided for in paragraph (2), the Sec-
3 retary may not make any adjustment to the ap-
4 plicable amount determined in paragraph (1)
5 for any year.

6 “(B) RULE OF CONSTRUCTION.—Nothing
7 in this subsection shall be construed to limit the
8 authority of the Secretary to risk adjust the
9 amount under subsection (c)(1)(D) pursuant to
10 clause (i) of such subsection.”.

11 (b) REFINEMENTS TO HEALTH STATUS ADJUST-
12 MENT.—Section 1853(a)(1)(C) of such Act (42 U.S.C.
13 1395w-23) is amended by inserting after the first sen-
14 tence the following new sentence: “In applying such ad-
15 justment for health status to such payment amounts, the
16 Secretary shall ensure that such adjustment reflects
17 changes in treatment and coding practices in the fee-for-
18 service sector and reflects differences in coding patterns
19 between Medicare Advantage plans and providers under
20 part A and B to the extent that the Secretary has identi-
21 fied such differences.”.

1 **SEC. 3154. CARVE-OUT OF THE INDIRECT COSTS OF MED-**
2 **ICAL EDUCATION FROM THE ADJUSTED AV-**
3 **ERAGE PER CAPITA COST FOR PURPOSES OF**
4 **CALCULATING THE ANNUAL**
5 **MEDICAREADVANTAGE CAPITATION RATE.**

6 Section 1853(c)(1)(D)(i) of the Social Security Act
7 (42 U.S.C. 1395w-23(c)(1)(D)(i)) is amended by insert-
8 ing “and (beginning with 2006) section 1886(d)(5)(B)”
9 before the period at the end.